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The Technique and Management of Pelvic Surgical Cases.

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The Technique and Management of Pelvic Surgical Cases.[1]

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THE treatment of purulent collections in the pelvis by means other than direct radical removal of the disease is, to my mind, unsurgical and utterly unworthy of trial. Those with little or no experience, and without confidence in their own ability, may advocate the palliative treatment which has been so popular in the past. The treatment of to-day—the one giving the best results—is the radical surgical therapy. The treatment of pus collections in the pelvis by incision and drainage per vaginam has been followed by the most unfortunate results; when death from sepsis did not follow, a long-protracted convalescence and prolonged subsequent treatment at the hands of the operator were necessary. It matters not what method of opening the pus collection within reach through the vagina, a prolonged after-treatment is necessary. What could be more unsurgical? The drainage is utterly imperfect, as, in the majority of cases, more than one abscess will be found, and opening one will not drain several. In my own experience the thickened mass of detritus left behind after such treatment is a constant menace to the future good health of the patient. It has been said by good authority that the tubercle bacillus finds the bodies of individuals with old chronic inflammatory masses in the pelvis favorite subjects to flourish in. I mention this *en passant*. I am an advocate of early operation in diseases of a purulent character, whether in the brain, chest, abdomen or pelvis. Delay is always followed by the most unfortunate chain of sequences.

The simple distention of the Fallopian tubes with pus in an early stage of disease will require but little time and no great operative skill to deal with in a proper manner—a median section. The original simple pus tube nursed on until, like leaven in the bread, every structure in the pelvis is involved, is a far different affair to deal with. Such cases require a tenacity of purpose and an experience not gained in the school of timidity—that school whose teaching is vaginal incision and many visits at so much

[1]Read by title, Kansas State Medical Society, May, 1891.

a visit. The exponent of ancient history in medicine will recall to the mind of the patient and friends that the removal of pyosalpinges will unsex. He ignores the fact that the individual is already unsexed and will go on to dissolution or remain in a state of chronic invalidism. The removal of appendages not diseased is an easy matter, and is only done by those inoculated with the *furor operativus bacillus* or those who are without conscience The removal of appendages thoroughly diseased can only be looked upon by all as the surgery of necessity. The preparations for such operations need be but few, and, inasmuch as we learn from experience, it may be of interest if we give our individual experience in the technique and management of such cases. The patient is prepared for operation, if time permits, by giving a general bath, and, before operating, thoroughly scrubbing the abdomen. To do this satisfactorily, the application of a strong solution of liquor potassa will be found in many respects superior to soap. I constantly carry a solution of liquor potassa in my emergency case, from which extemporaneous solutions to cleanse the parts can be made as required. The great advantage of the solution mentioned is that when time is an object, more perfect cleansing can be obtained with less effort than by any other means with which I am acquainted. I have cleaned the field of major operations in a few minutes with this solution in an emergency, when the parts were filthy beyond description, and secured union by first intention throughout. Surrounding the field of operation I place sheets of unbleached muslin. These are one yard and a half in length, one yard wide, and are prepared by boiling in a three per cent. carbolic acid solution, and dried by ironing while damp. Each extremity is wrapped in one of these sheets, and others arranged above and below the line of proposed incision. One or more of these sheets are wrung out in some antiseptic solution and placed over the dry sheets at the time of operating, thus lessening the danger of chilling the patient. It is advisable to boil the instruments for fifteen or twenty minutes while the patient is being prepared for the operation. I find that the granite ironware drip-pans serve a most excellent purpose in which to sterilize the instruments, and I always carry them with me. A thoroughly practical operating case can be devised by taking two such pans, packing instruments and dressing in one and using the other for a cover, a shawl strap holding all in compact form. A convenient way to carry laparotomy instruments is in roll cases made of white ducking, ideal cleanliness being always maintained, as the roll, with its contents, may be sterilized at short notice by simply placing it in an oven—a good plan to follow out after cleansing the instruments—the dry heat insuring perfect drying of the same.

The incision should be short, and later on extended if necessary. It is well in all cases to know the condition of the patient's bladder before operating. An incompletely closed urachus has been met with by a number of operators, and an adherent bladder is not unique. On opening the peritoneal layer a digital examination will decide whether the operation can be completed or not. Adhesions

will always be found where a circumscribed peritonitis has existed. If the omentum is directly in the way and very greatly adherent, it is better to tie it off *en masse* than to waste time in attending to it at once. The adherent portions may be treated after completing the more important parts of the operation. In pus collections within the pelvis no treatment will compare with the absolute removal. This task may be most difficult because of the firm adhesion we find, especially in old chronic cases, but with perseverance and care, with the anatomy of the danger lines ever in mind, adhesions which seemed incapable of separation, will, with patience, give way. When the pus collections rupture in the process of removal, what would have been a perfect specimen has been spoiled, but that is all. The escape of pus might be looked upon as nothing short of a calamity by those who have had no experience, but operators of experience have little anxiety over such accidents. They are unavoidable. It is a waste of valuable time to aspirate such fluid collections, and no one except idealists without experience advocate such a procedure. Not one case of pyosalpinx or ovarian abscesses in fifty can be aspirated with positive assurance that leakage will not take place. The walls of the pelvic abscesses vary in thickness in almost every instance; at least, that is my experience. No matter how careful one may be, ruptures will take place and pus escape when the abscess ruptures. I am convinced it is bad surgery to stop the process of enucleation and at once try and cleanse the field of operation. It is far better to completely remove the morbid material and then thoroughly flush out the abdomen. To flush the abdomen, water should be poured in at a temperature of from 105° to 110°, and in large quantities; an ordinary water pitcher, or, better, a water carrier, will answer the purpose. Drainage after laparotomy is one of the most important subjects for consideration. From my own experience I feel that every case should be drained. The tube should be left in for a few hours to several days and, indeed, in some cases until convalescence is established. I have never seen anything but good come from the tube, and I have seen fatal results follow the non-use of the tube. It is not necessary to use the large tubes furnished by the instrument makers. The tube used by Price is one of the best. I have modified his tube by having a shoulder made an inch from the end. The tube used after all my laparotomies is only three-eighths of an inch in diameter. If necessary, where there is a probability of free drainage of an unhealthy character, as in the case of acute general peritonitis, several of these tubes may be introduced along the line of incision, and extra strips of gauze placed outside the tubes carrying them to the bottom of the cavity. In cases of puerperal peritonitis (which are so fatal when the peritonitis is general, treated by the conservative-do-nothing plan), it cannot be contradicted that the only hope for such patients is by section, removal of the tubes and ovaries, and free flushing of the abdomen and pelvis. This class of cases is, as a rule, the most desperate of all the abdominal cases the surgeon is called upon to treat. If, in the very early stages of the disease,

free purgation and the usual therapy do not cause a disappearance of the urgent symptoms, nothing short of radical measures will succeed. I have operated on several cases of diseased appendages, the direct result of abortions, and with success, with one exception. This case will be reported in another paper at length. The outlook for the unfortunates who have a developed general peritonitis, which was formerly regarded as fatal, grows brighter, and the practitioner or surgeon who would stand back and allow the ravages of the disease to be unchecked without an effort shows a censurable, inexcusable inactivity. With definite symptoms of peritonitis unrelieved by the usual treatment, no time should be lost in introducing the radical measure—a section, irrigation and drainage—and a prompt relief will follow in a large percentage of cases where this treatment is adopted.

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